VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

May 14, 2012

Mr. Daniel Daly, Administrator
Kindred Transitional Care & Rehab Birchwood Terrace
43 Starr Farm Rd.
Burlington, VT 05408-1321

Provider #: 475003

Dear Mr. Daly:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **April 11, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS
Licensing Chief

PC:ne

Enclosure

PRINTED: 04/25/2012
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 475003 | A. BUILDING _____ B. WING _____ | 04/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| KINDRED TRANSITIONAL CARE & REHAB BIRCHWOOD TER | 43 STARR FARM RD BURLINGTON, VT 05408 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS<br><br>An unannounced, on-site recertification survey was conducted by the Division of Licensing and Protection from 04/09/2012 to 04/11/2012. The following regulatory deficiencies were identified:<br><br>F 241 SS=E 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews the facility failed to assure dignity for residents on Unit A during the dining experience on 04/09/2012. Findings include:<br><br>1. Per observation at lunch on Unit A on 04/09/12 at 12:20 PM Residents #212, #90 and #134 were seated at a table with 3 other residents who were being fed starting at times of 12:30 - 12:50 PM. The identified residents sat at the table while other residents were fed and the 3 identified residents were not assisted with eating until 1:30 - 1:40 PM. The staff who began feeding these residents stated that the residents were waiting for that length of time because there was no one available to feed them.<br><br>At a second table for 6 Residents #136, #154, and # 171 were seated with 3 other residents (all requiring feeding or extensive assistance) who were served from 12:40 PM - 12:55 PM. The 3 identified residents were not served until 1:45 PM | F 000 | F 241<br>A dining plan for residents' # 134, 136, 154, 171, 148, 115 and 108 80 and 166 was established to assure that tablemates eat at the same time. Resident #90 expired 4/18/12.<br><br>F 241<br>The DNS and/or the Nurse Managers will identify through observation of meal service other residents that may be affected. An interdisciplinary dining committee has been established for the benefit of the residents on the Special Care Unit. The DNS or Nurse Manager will educate nursing staff to assure that an appropriate seating plan and meal service is established to maintain each resident's dignity during meal service.<br><br>The DNS or her designee will educate nursing staff on the establishment of a seating plan for all dining rooms that serve residents. Nurse managers and charge nurses will then monitor dining rooms for changes that may need to be made based on resident need.<br><br>The DNS or her designee will assure through observation and interview that residents are seated appropriately in dining rooms and eating at the same time as their tablemates. Results of these audits will be reported to the monthly PI committee. The Administrator is responsible for over all compliance.<br><br>F241 POC accepted 5/10/12<br>GColemanRN/DMcotaRN | May 11, 2012 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

May 3rd 2012

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 241 | Continued From page 1<br>and the staff feeding them stated that there was no staff available to feed these residents any earlier. The residents were still being fed lunch at 2:45 PM.<br><br>In another section of the dining room, residents were seated in easy chairs with tray tables. Resident #148 was seated next to a resident who had received a lunch tray. Resident #148 had not received a lunch tray and requested that s/he "have some of that food", pointing to the other resident's tray. She requested food several times and was given a small bowl of potato chips and a glass containing apple juice. S/he continued to request "please can I have some-just a little of that food?". She waited 45 minutes for her tray to arrive and be served to her.<br><br>Two other residents (#115 and #108) were witnessed becoming increasingly restless as they awaited meal service while other residents were eating. Resident #115, who walks with a wheeled walker, got up several times and walked without the walker. At one point she was rummaging through a cabinet in the dining room. Resident #108, seated in a restraining chair with a tray, due to falls risk, released his/her tray 3 times while awaiting his/her food tray.<br><br>Per observation in room 121 B at 1:40 PM, Resident #80 called out to the passing surveyor asking "can I have a glass of milk or some food?" In room 120 B at 1:40 PM, Resident #166 remained in bed where s/he was fed by the Director of Nursing Services who acknowledged that the resident would normally eat in the dining room but s/he had not yet had morning care. | F 241 | | |

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| F 241 | Continued From page 2<br>Refer also to F353. | F 241 | *This Plan of Correction is the center's credible allegation of compliance.*<br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F 248 SS=E | 483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES<br>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff and family interviews, the facility failed to provide an ongoing program of activities designed to meet the the interests and well-being of each resident, based on the comprehensive assessment and individualized plans of care, for residents residing on the Special care Unit (Unit A). Findings include:<br><br>1. Per observation on 04/09/2012, several residents were seated in the common area of Unit A in the morning. Music was playing in that area and residents were dozing or seated in the room not engaged in an activity. In the afternoon on 04/09/2012 eight residents were observed in the common area with a staff member reading a story. Two residents were becoming restless, while four residents dozed. The remaining two residents were awake and exchanging some conversation with the staff person reading the story at times. A ninth resident was in the area off and on as s/he wandered in and out of the area while wandering the unit. Other residents with independent mobility came briefly and left throughout the reading. | F 248 | F 248<br><br>The Special Care Unit Program Director's role has been revised to include weekly designated time to develop meaningful resident specific activities based on resident's strengths and preferences.<br><br>Current residents will be reassessed to ensure care plans address resident specific activities based on resident strengths and preferences.<br><br>The Special Care Unit Program Director will coordinate activities on the Special Care Unit with the Activity Director and activity assistants.<br><br>The Special Care Unit Program Director will meet with the DNS and ED weekly times 3 months to review the compliance plan. Findings will be reported to the monthly Performance Improvement Committee meeting.<br>The ED is responsible for overall compliance.<br><br>F248 POC accepted 5/10/12<br>GColemanRN/AMcotaRN | May 11, 2012 |

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| F 248 | Continued From page 3 | F 248 | | |

In conversation, one family member asked to speak with a surveyor, wishing to remain anonymous. S/he stated that the activity program was not what was posted on the wall. S/he stated that the residents were often just sitting with music or the TV playing and that the exercise and other engaging activities had not happened for several months. This family member added that in the second and third day of survey more activities than usual occurred on Unit A. In a family interview, conducted in Stage I of the survey, a family member stated that, usually the activity was simply music playing on the unit while residents sat in the common room. S/he stated that frequently there was no staff present in the room to monitor and/or assist residents during this time. In a staff interview the Unit Program director confirmed that the number of hours per week for activities staff had been recently reduced by the corporate office.

In a review of Unit A activities, there are two activity schedules posted on the wall of the common room. The first is a schedule of the day, called "Birchwood Terrace Healthcare-Special Care Unit Here's what we do each day!" This list includes Rise and Shine (AM Care by LNA's), Musical Chairs (moving residents to their chairs for lunch while music plays), Cafe' Birchwood (lunch) and Supper Club (dinner) a dining group of 8 residents who go to the Main Dining Room for these meals, Blissful Relaxation (afternoon naps in beds or resting in chairs), and Good Morning and Afternoon at the Terrace (AM and Afternoon Snacks in the common area or resident rooms with music playing in the common area). There are also activities such as sensory

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| F 248 | Continued From page 4<br>activities, morning stretch, words and music, game time, and soothing the senses listed. After dinner activities include Memories of the Small Screen (television with old TV shows (reminiscing) or music) and Enchanted Evening (HS care and a movie for those who care to watch). This was confirmed in an interview with the Unit Program Director on 04/11/2012 at 4:30 PM.<br><br>Activities listed on the monthly schedule include Bingo in the Main Dining Room (attended by 2 Unit A residents) Saturdays include alternating Arts & Crafts and Ice Cream Social. In interview the Program Director states that the Arts & Crafts is primarily coloring, while staff states that on occasion some residents do scrapbooking. The Ice cream social is residents gathered in the common areas for ice cream and "socializing". Each day on this monthly schedule lists two activities (which include Bingo attended by two residents off unit A each Friday and occasional Saturdays) and visits by the facility hairdresser (who is assisted on the unit by activities staff) every Thursday (not all residents are involved in hair dresser visits). On three days in March and three days in April there are music activities in the main dining room attended by "as many residents as possible" from A Unit according to the program director. S/he stated that although they would like to have special music presentations for Unit A this was not financially feasible. "We need to get the most bang for our buck." | F 248 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's | F 279 | | |

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| F 279 | Continued From page 5<br>comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and interview, the facility failed to develop a comprehensive plan of care that included fall interventions initiated at the time of admission for one Resident (#144) assessed to be at high risk for falls. This affected one (#144) of 17 Resident records reviewed for comprehensive plans of care. Findings include:<br><br>Per clinical record review on 04/10/12, Resident #144 was admitted on 01/21/12 with a non operable femoral neck fracture (broken hip) sustained in a fall prior to admission to the facility. Review of the Patient Nursing Assessment of the same date revealed a Morse Fall Risk Scale score of 70 (45 and higher indicates high fall risk). Review of the Bed Safety Evaluation dated | F 279 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>F 279<br><br>Resident # 144 care plan was updated to reflect use of clip alarm to alert staff of resident's attempts to transfer without assistance.<br><br>Current residents assessed to be at high risk for falls will be reviewed for care plan interventions. Care plans will be developed for any resident without a care plan.<br><br>The DNS or her designee will educate staff on the care plan process for fall prevention.<br><br>Audits (record review) of residents with high risk for falls will be conducted to ensure a plan of care is in place.<br><br>Results of these audits will be reported to the monthly PI committee and changes will be done as needed. The DNS is responsible for overall compliance.<br><br>F279 POC accepted 5/10/12<br>G.Coleman RN/ A Nicotra RN | May 11, 2012 |

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| F 279 | Continued From page 6 | F 279 | | |

1/21/12 and the Treatment Records for January through March 2012, revealed no indication of the use of an alarm. Review of the Resident Progress Notes dated 1/21/12 at 10:35 P.M. revealed that a clip alarm was in place. The Progress Notes periodically mention the use of a clip alarm to alert staff to the Residents attempts to transfer without assistance between 1/21/12 and 3/31/12.

On 3/12/12 at 9:00 A.M. an Event Assessment indicated that Resident #144 was observed kneeling in front of a chair with no clip alarm in place. The Plan of Care for falls, dated 02/03/12, indicated Resident #144 had a fall prior to admission with a right hip fracture, used medications that affected fall risks and used a wheelchair. The Plan of Care indicated that Resident #144 had a fall on 3/12/12 and slid out a chair secondary to having no clip alarm in place.

Interview of the Registered Nurse, Unit Manager on 04/10/12 at 4:45 P.M. revealed that an alarm was initiated on 01/21/12, as a result of the fall risk assessment score, but was not written on the triplicate form and as a result, was not flowed on the Treatment Record for the nurses to track, or noted on the comprehensive Plan of Care for falls.

On 4/11/12, at 8:40 A.M., the RN, unit manager stated that a clip alarm had been used since admission and should have been tracked by the nurses on the treatment record and should have been reflected on the plan of care. S/he verified that the Plan of care did not comprehensively reflect the interventions in place since admission and was not updated on 03/12/12, when a fall

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| F 279 | Continued From page 7<br>occurred without the alarm intervention in place.<br>F 323 483.25(h) FREE OF ACCIDENT<br>SS=D HAZARDS/SUPERVISION/DEVICES<br><br>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on clinical record review and interview, the facility failed to consistently implement a fall intervention for one resident assessed to be at high risk for falls resulting in a fall with a pelvic fracture. This affected one (#144) of three sampled Resident records reviewed for accidents. Findings include:<br><br>Per clinical record review on 04/10/12, Resident #144 was admitted on 01/21/12 with a non operable femoral neck fracture (broken hip) sustained in a fall prior to admission to the facility. Review of the Patient Nursing Assessment of the same date revealed a Morse Fall Risk Scale score of 70 (45 and higher indicates high fall risk). Review of the Bed Safety Evaluation dated 1/21/12 and the Treatment Records for January through March 2012, revealed no indication of the use of an alarm. Review of the Resident Progress Notes dated 1/21/12 at 10:35 P.M. revealed that a clip alarm was in place. The progress notes periodically mention the use of a clip alarm to alert staff to the Residents attempts | F 279<br>F 323 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>F 323<br><br>Resident # 144 care plan was updated to reflect use of clip alarm to alert staff of resident's attempts to transfer without assistance.<br><br>Current residents assessed to be at high risk for falls will be reviewed for care plan interventions. Care plans will be developed for any resident without a care plan.<br><br>The DNS or her designee will educate staff on the care plan process for fall prevention.<br><br>Audits (record review) of residents with high risk for falls will be conducted to ensure a plan of care is in place.<br><br>Results of these audits will be reported to the monthly PI committee and changes will be done as needed. The DNS is responsible for overall compliance.<br><br>F323 POC accepted 5/10/12<br>GColemanRN/ DMeotaRN | May 11, 2012 |

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| F 323 | Continued From page 8<br>to transfer without assistance between 01/21/12 and 03/31/12.<br><br>On 3/13/12 an Event Assessment indicated that Resident #144 was observed kneeling in front of a chair with no clip alarm in place. The Plan of Care dated 02/03/12, indicated Resident #144 had a fall prior to admission with a right hip fracture and used a walker. The Plan of Care indicated that Resident #144 had a fall on 03/12/12 and had slid out a chair secondary to having no clip alarm in place. A mobile x-ray report dated 03/12/12 indicated a left pelvic fracture resulted. Resident #144 was non weight bearing from 8:30 P.M. on 03/12/12 until 12:20 P.M. on 03/13/12 when therapy treatment was resumed, per physician's orders. There was no indication that Resident #144 had a significant change in function related to the fracture.<br><br>Interview of the Registered Nurse (RN), Unit Manager on 04/10/12 at 4:45 P.M. revealed that a clip alarm was initiated on 01/21/12 but was not written on the triplicate form and, as a result, was not flowed on the Treatment Record for the nurses to track or noted on the comprehensive Plan of Care for falls. On 4/11/12, at 8:40 A.M. the RN, unit manager stated that the alarm had been used since admission and should have been tracked by the nurses on the treatment record and should have been reflected on the plan of care. S/he verified that the alarm was not in place at the time of the fall on 03/12/12 and should have been in place due to frequently documented attempts to transfer without assistance. S/he verified a pelvic fracture was sustained as a result. | F 323 | | |
| F 353 | 483.30(a) SUFFICIENT 24-HR NURSING STAFF | F 353 | | |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 353 SS=E | Continued From page 9<br>PER CARE PLANS<br><br>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.<br><br>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:<br><br>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.<br><br>~~Except when waived under paragraph (c) of this~~ section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interviews, the facility failed to assure sufficient staff to provide nursing and related services to maintain the highest practicable well-being of each resident ~~according to resident assessments and individual~~ plans of care. Findings include:<br><br>1. Per observation at lunch on Unit A on 04/09/12 at 12:20 PM Residents #212, #90 and #134 were seated at a table with 3 other residents who were being fed starting at times of 12:30 - 12:50 PM. | F 353 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>F 353<br><br>Residents # 212, 134, 154, 171, 148, 115 108, 80, 136 and 166 have been reevaluated to ensure they receive their meals in a timely manner. Resident #90 expired 4/18/12.<br><br>The process for delivering personal care, timely meals and meaningful resident specific activities has been revised to meet the needs of the residents on the Special Care Unit.<br><br>The Special Care Unit Program Director and Special Care Unit Manager will coordinate efforts to ensure the revised, structured process is implemented and maintained.<br><br>The DNS will meet with the SCU Program Director and SCU Nurse Manager weekly times 3 months to review compliance with plan. Findings will be reported to the PI committee monthly x3 months.<br><br>The ED is responsible for overall compliance.<br><br>F353 POC accepted 5/10/12 GColeman RN/ PNcotaRN | May 11, 2012 |

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|---|---|---|---|
| | 475003 | A. BUILDING _____ B. WING _____ | 04/11/2012 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| F 353 | Continued From page 10 | F 353 | | |

The identified residents sat at the table while other residents were fed and the 3 identified residents were not assisted with eating until 1:30 - 1:40 PM. The staff who began feeding these residents stated that the residents were waiting for that length of time because there was no one available to feed them.

At a second table for 6 Residents #136, #154, and # 171 were seated with 3 other residents (all requiring feeding or extensive assistance) who were served from 12:40 PM - 12:55 PM. The 3 identified residents were not served until 1:45 PM and the staff feeding them stated that there was no staff available to feed these residents any earlier. The residents were still being fed lunch at 2:45 PM.

In another section of the dining room, residents ~~were seated in easy chairs with tray tables.~~ Resident #148 was seated next to a resident who had received a lunch tray. Resident #148 had not received a lunch tray and requested that s/he "have some of that food", pointing to the other resident's tray. She requested food several times and was given a small bowl of potato chips and a glass containing apple juice. S/he continued to request "please can I have some-just a little of that food?". She waited 45 minutes for her tray to arrive and be served to her.

Two other residents (#115 and #108) were witnessed becoming increasingly restless as they awaited meal service while other residents were eating. Resident #115, who walks with a wheeled walker, got up several times and walked without the walker. At one point she was rummaging through a cabinet in the dining room. Resident

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| F 353 | Continued From page 11<br>#108, seated in a restraining chair with a tray, due to falls risk, released his/her tray 3 times while awaiting his/her food tray.<br><br>Per observation in room 121 B at 1:40 PM, Resident #80 called out to the passing surveyor asking "can I have a glass of milk or some food?" In room 120 B at 1:40 PM, Resident #166 remained in bed where s/he was fed by the Director of Nursing Services who acknowledged that the resident would normally eat in the dining room but s/he had not yet had morning care.<br><br>Refer also to F241.<br><br>2. Per observations on 04/09/12 at 12:40 PM on Unit A, Resident # 115 was observed walking without her walker and rummaging through a cupboard. Per record review, Resident #115 is a Falls Risk and his/her care plan calls for staff to monitor him/her and for use of a walker when ambulating. The Resident was without her walker for several minutes until the surveyor called staff attention to the resident. During the same period of observation, Resident #108 was observed at the same lunch service seated in a tray restraint chair awaiting lunch service. At 12:55 PM and 1:05 PM the Resident was observed to have loosened his/her restraining tray, which was in place for safety to prevent falls according to the record. The first time s/he loosened the restraint tray, the surveyor called it to the staff's attention after several minutes when he began leaning forward in his chair.<br><br>3. In a review of the residents during an interview with the Unit Manager on 04/11/12, on Unit A (the Special Care Unit) there are 50 residents. Of | F 353 | | |

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| F 353 | Continued From page 12<br>those 50 residents, 6 residents require total care, total assistance with eating, and require transfer via a Hoyer Lift. 14 residents require total care, total assistance with eating, and a transfer assist of 1 or 2. An additional 10 residents require total care and some assistance or monitoring with eating and transfers. The remaining residents on the unit all require some level of assistance or supervision in some or all aspects of care and a number of the entire unit census experience resistance to care at some level. In summary, 30 residents require total care for hygiene and grooming and all residents require care and monitoring. According to the Unit Manager staffing is usually 5 LNAs (Licensed Nursing Assistants) however there are frequent days when there are call-ins or only 4 LNAs to care for the residents. Nurses may be pulled to caregiver positions to assist in providing direct care. | F 353 | | |
| | In a review of the provided schedule dated March 2, 2012 to March 29, 2012 there were 6 LNAs assigned to Unit A on only 1 day, there were 5 LNAs assigned on 5 days, 4 LNAs assigned on 15 days, 3 LNAs assigned on 5 days and 2 LNAs assigned on 2 days to care for 50 Special Care Unit residents. On all days, except the 2nd, 3rd, 27th and 28th of March, there were additional shifts scheduled ranging in length of time and combination; however, 9 of these were one 2 hour additional shift. (Where two partial shifts comprised a whole 6:30 to 2:30 shift, or other straight 8 hours, the number of staff above was adjusted.)<br><br>Refer also to F9999. | | | |
| F 356 SS=C | 483.30(e) POSTED NURSE STAFFING INFORMATION | F 356 | | |

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| F 356 | Continued From page 13<br>The facility must post the following information on a daily basis:<br>o Facility name.<br>o The current date.<br>o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:<br>- Registered nurses.<br>- Licensed practical nurses or licensed vocational nurses (as defined under State law).<br>- Certified nurse aides.<br>o Resident census.<br><br>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:<br>o Clear and readable format<br>o ~~In a prominent place readily accessible to~~ residents and visitors.<br><br>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.<br><br>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observations during the 3 days of survey, the posted nursing staffing for the facility does not include the total number of hours worked by licensed and unlicensed personnel, | F 356 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*<br><br>F 356<br><br>No residents were found to be affected by the deficient practice.<br><br>No residents have the potential to be affected by the deficient practice.<br><br>The center will post a form which includes total nursing hours and census every day.<br><br>Compliance will be monitored and reported monthly at the facility PI meetings for 3 months or until 100% compliance achieved. The administrator is responsible for overall compliance.<br><br>F356 POC accepted 5/10/12<br>GColeman RN/DMotaRN | May 11, 2012 |

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| F 356 | Continued From page 14<br>nor does it include the facility census. The specifics are as follows:<br><br>Per observation during the 3 days of survey, the nursing staffing for the day is posted in the facility lobby but does not include the daily census nor the total number of hours worked by the individual disciplines. This is confirmed during interview with the facility administrator on 04/11/2012 at 8:50 am. | F 356 | *This Plan of Correction is the center's credible allegation of compliance.*<br><br>*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* | |
| F9999 | FINAL OBSERVATIONS<br><br>Vermont Licensing and Operating Rules for Nursing Homes<br>7.13 Nursing Services<br>(d) Staffing Levels. The facility shall maintain staffing levels adequate to met resident needs.<br>(1) At a minimum, nursing facilities must provide:<br>(i) no fewer than 3 hours of direct care per resident per day, on a weekly average, including nursing care, personal care and restorative nursing care, but not including administration or supervision of staff; and of the three hours of direct care, no fewer than 2 hours per resident per day must be assigned to provide standard LNA care (such as personal care, assistance with ambulation, feeding, etc.) performed by LNAs or equivalent staff and not including meal preparation, physical therapy or the activities program.<br><br>This REQUIREMENT is not met as evidenced by:<br><br>1. In a review of the residents during an interview with the Unit Manager on 04/11/12, on Unit A (the Special Care Unit) there are 60 residents. Of those 50 residents, 6 residents require total care, total assistance with eating, and require transfer | F9999 | F9999 May 11, 2012<br><br>The process for delivering personal care, timely meals and meaningful residents specific activities has been revised to the meet the needs of the residents on the SCU.<br><br>The facility has advertised for open positions in various local and New York newspapers. An open house was held April 11, 2012. The SDC and DNS are interviewing candidates for an LNA training program scheduled to begin at or around May 14, 2012.<br><br>The DNS and or designee is responsible for tracking and recruiting for open positions in the nursing department.<br><br>Open positions will reviewed at the monthly PI committee meeting with appropriate recommendations ongoing.<br><br>The ED is responsible for overall compliance.<br><br>F9999 POC accepted 5/10/12<br>GColeman RN/ RMeotaRN | |

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| F9999 | Continued From page 15<br>via a Hoyer Lift. 14 residents require total care, total assistance with eating, and a transfer assist of 1 or 2. An additional 10 residents require total care and some assistance or monitoring with eating and transfers. The remaining residents on the unit all require some level of assistance or supervision in some or all aspects of care and a number of the entire unit census experience resistance to care at some level. In summary, 30 residents require total care for hygiene and grooming and all residents require care and monitoring. According to the Unit Manager staffing is usually 5 LNAs (Licensed Nursing Assistants) however there are frequent days when there are call-ins or only 4 LNAs to care for the residents. Nurses may be pulled to caregiver positions to assist in providing direct care.<br><br>In a review of the provided schedule dated March 2, 2012 to March 29, 2012 there were 6 LNAs assigned to Unit A on only 1 day, there were 5 LNAs assigned on 5 days, 4 LNAs assigned on 15 days, 3 LNA's assigned on 5 days and 2 LNA's assigned on 2 days. On all days, except the 2nd, 3rd, 27th and 28th of March, there were additional shifts scheduled ranging in length of time and combination however 9 of these were one 2 hour additional shift. (Where two partial shifts comprised a whole 6:30 to 2:30 shift, or other straight 8 hours, the number of staff above was adjusted. In a review of number of hours per day per resident of LNA care, the monthly average for the month of March was 1.88 hours per day per resident of LNA care. In interview on 04/10/2012, the Director of Nurses states that the facility supplements fewer nurses aides by moving nursing staff. The overall average of hours per resident for care by all nursing staff for | F9999 | | |

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| F9999 | Continued From page 18 | F9999 | | |

the month of March was 3.31 with four days below 3 hours per resident of direct care staff.

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| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # 475003 | MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | DATE SURVEY COMPLETE: 4/11/2012 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| KINDRED TRANSITIONAL CARE & REHAB BIRCH | 43 STARR FARM RD BURLINGTON, VT |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
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| F 247 | 483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE |

A resident has the right to receive notice before the resident's room or roommate in the facility is changed.

This REQUIREMENT is not met as evidenced by:
Based upon interview and record review, the facility failed to provide notice to 1 of 3 residents and/or their representatives before the resident's room was changed. (Resident #198) Finding includes:

Per record review and interview with the Social Worker on 4/11/12 at 4:07 PM, there is no documentation in the record or on the facility "Notification of Room Change", that Resident #198 and/ or the representative were notified when the resident was moved on 12/2/11 from a room on C-Wing to another room on C-Wing. Also, per record review and interview with the Social Worker on 4/11/12 at 3:32 PM, there is no documentation in the record or on the facility "Notification of Room Change" , that Resident #198 and/or the representative were notified when the resident was moved on 3/26/12 from C-Wing to B-Wing. In addition, the facility's "Notification of Room Change" documents when the resident or resident's representative was notified, reason for room change, if the move was voluntary, and is signed by the resident or representative. The facility's "Room to Room Transfer" procedure states "Notify the patient and responsible party in advance of the transfer" and "Provide the transferring patient with an opportunity to tour the room prior to the move and introduce the patient to his/her new roommate".

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents

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If continuation sheet 1 of 1